

## CERTIFICATE OF DEATH

16868

17884

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M	
Gilbert				CHASE	Dec. 30 1967			
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male	Negro		Dec. 28, 1967		YRS. 2		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Maryland	USA				CHARLES		Md.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
La Plata	Physicians Mem. Hosp.		Infant					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.	Charles		Bel Alton					
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Joseph			Chase	Eleanor				Hawkins
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT				
No		None		Joseph Chase, Bel Alton, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atlectasis</u> 7625 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity 1#120g</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12-30-67 12-28-67								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)				
E.J. EDELEN		12-31-67		E.J. EDELEN, M.D.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		Jan. 1, 1968		St. Ignatius		Chapel Point, Charles, Md.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Arehart Funeral Home Inc.		La Plata, Md.		DATE JAN 10 1968		J. Charles Jones		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print) <b>ALICE CECELIA COLE</b>			2a. DATE OF DEATH Month <b>December</b> Day <b>27</b> , Year <b>1967</b>		2b. HOUR M
3. SEX <b>Female</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH <b>October 10, 1915</b>		6. AGE (In years last birthday) <b>52</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Charles</b> Md.		
10. CITY OR TOWN OF DEATH <b>La Plata</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Physicians Memorial Hospital</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Charles</b>	13c. CITY OR TOWN <b>Wicomico</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>(Rural)</b>	
14. FATHER'S NAME First Middle Last <b>Jack Campbel</b>	15. MOTHER'S MAIDEN NAME First Middle Last <b>Estelle (Unkown)</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) <b>No</b> (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Dora Alinen Thomas -Chaptico, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Hemorrhagic Pancreatitis</b> <b>5870</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Chronic glomerulonephritis - Hypertensive Cerebrovascular Disease</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from <b>12-26-67</b> , 19__, to <b>12-27-67</b> , 19__, that (I) (we) lost the deceased alive on <b>12-27-67</b> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>J. PARRAN JARBOE M.D.</b>	DEGREE <b>M.D.</b>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>12-29-67</b>		
22d. PHYSICIAN'S NAME (Type) <b>J. PARRAN JARBOE M.D.</b>	22e. ADDRESS <b>LA PLATA, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12/30/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Newport, Maryland</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Arehart Funeral Home, Inc.-La Plata, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 3 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>C</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Charlotte Hall, Md</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>FRANCIS</b> Middle <b>LEROY</b> Last <b>COLE</b>		4. DATE OF DEATH Month <b>12</b> Day <b>21</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-3-58</b>
9. AGE (In years lost birthday) yrs. <b>9</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STUDENT</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>CHARLES, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>FRANK PERRY DYLEN</b>	
14. MOTHER'S MAIDEN NAME <b>ALICE COLE</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mother Charlotte Hall, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LOBAR PNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>12-18</b> , 19 <b>67</b> , to <b>12-21</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12-18</b> 19 <b>67</b> , and that death occurred at <b>6 A</b> M, from causes and on the date stated above.	
22a. SIGNATURE <b>F.M. Johnson M.D.</b>		22b. DATE SIGNED <b>12-22-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>F.M. JOHNSON M.D.</b>		22d. ADDRESS <b>LA PLATA, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>12/23/67</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>Church Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Charles County</b>	
24. FUNERAL DIRECTOR <b>Leroy E. Berry</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>JAN 16 1968</b>	

1881

ENTRATA DE 40 IN

1881

Prout Reef Dated

Charles W. Hall, Jr.

12/20/81 Church Council



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16871

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16864

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LA PLATA</u>		c. LENGTH OF STAY IN 1b <u>WHITE PLAINS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PHYSICIANS MEMORIAL Hosp.</u>		d. STREET ADDRESS <u>08-1</u>	
3. NAME OF DECEASED (Type or print) <u>FRANK EDWARD CONNELL</u>		4. DATE OF DEATH Month <u>12</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 9, 1888</u>
9. AGE (In years last birthday) yrs. <u>79</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TOBACCO</u>	
11. BIRTHPLACE (State or foreign country) <u>COLORADO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM E. CONNELL</u>		14. MOTHER'S MAIDEN NAME <u>FRANCES GIRARDOT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>579-07-1097</u>	
17. INFORMANT <u>ROSE CONNELL, WHITE PLAINS, MD.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4201 DUE TO (b) <u>Gun cut free</u> DUE TO (c) <u>1</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>12:18</u> p.m. <u>1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>White Plains Charles MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. J. Edelen</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>LA PLATA, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-21-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>WASH. NAT. CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>SUITLAND P.G., MD.</u>	
24. FUNERAL DIRECTOR <u>HUNTT FUNERAL HOME, WILDORE, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 28 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

THE UNIVERSITY OF MICHIGAN LIBRARY

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1918-19

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 16872 CERTIFICATE OF DEATH 16865											
1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>md</b> b. COUNTY <b>CHARLES</b>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LA PLATA</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WHITE PLAINS, MD</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>PHYSICIANS MEMORIAL HOSPITAL</b>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>WILLIAM GWYNN DAVIS</b>		First Middle Last		4. DATE OF DEATH <b>12 19 1967</b>		Month Day Year					
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-26-1882</b>		9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>			11. BIRTHPLACE (County & State, or foreign country) <b>CHARLES, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>GWYNN DAVIS</b>					14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>212-16-4810</b>		17. INFORMANT <b>Otis Davis White Plains, Md.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sen Ant Soc</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>11-27-1967</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>11-27-67</b> to <b>12-19-67</b> , that (I) (we) last saw the deceased alive on <b>12-19-67</b> , and that death occurred at <b>2:00</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>E. J. EDELEN</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>E. J. EDELEN</b>					22d. ADDRESS <b>LA PLATA, MD</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-22-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls</b>		23d. LOCATION (City, town or county) (State) <b>WALDORF CHAS. MD.</b>					
24. FUNERAL DIRECTOR <b>HUNTT FUNERAL HOME WALDORF, MD</b>					ADDRESS		25a. REC'D BY REGISTRAR <b>DEC 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

20th COLONY FEB

CHATELAIN W. DEBIA



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

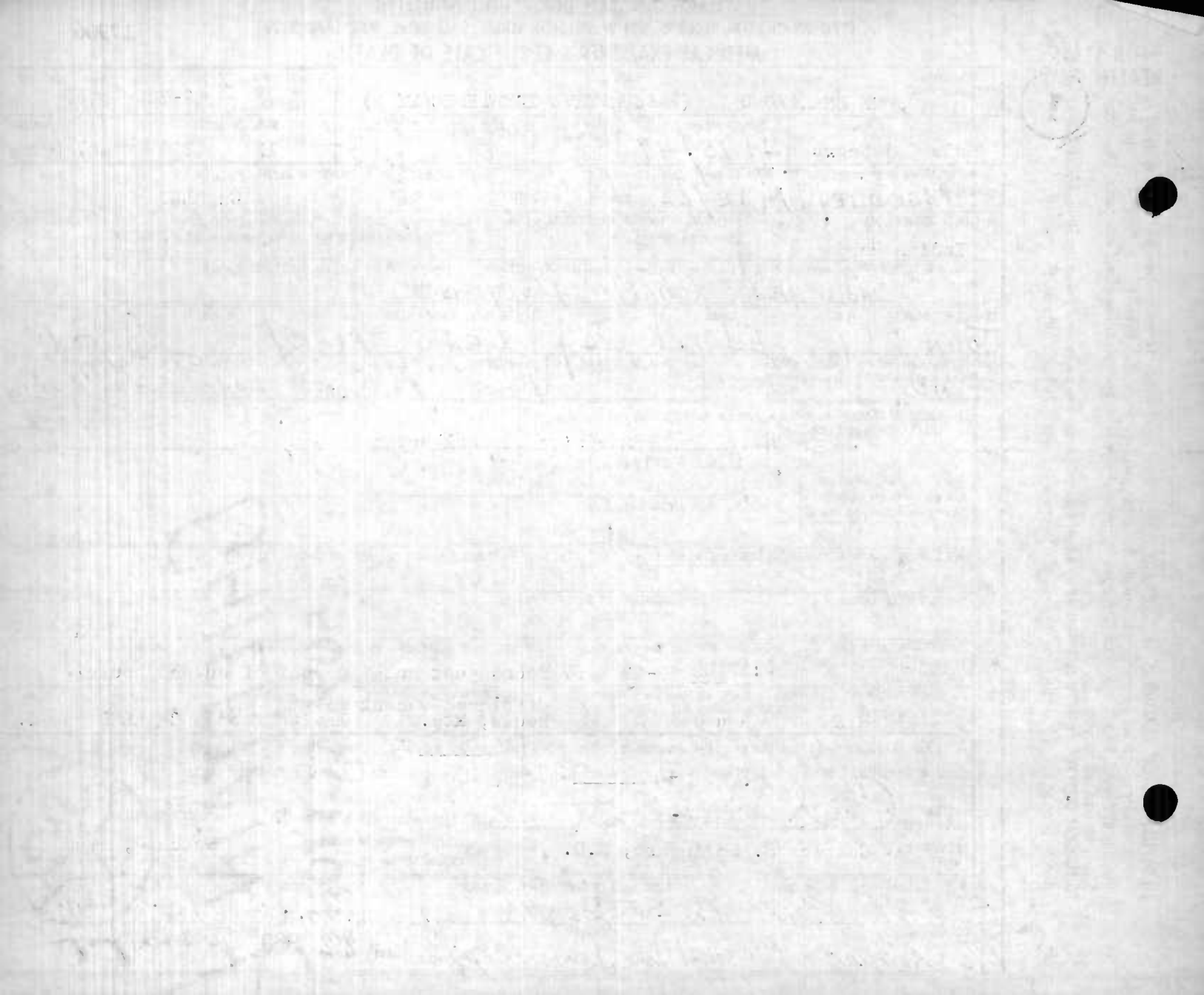
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17906

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

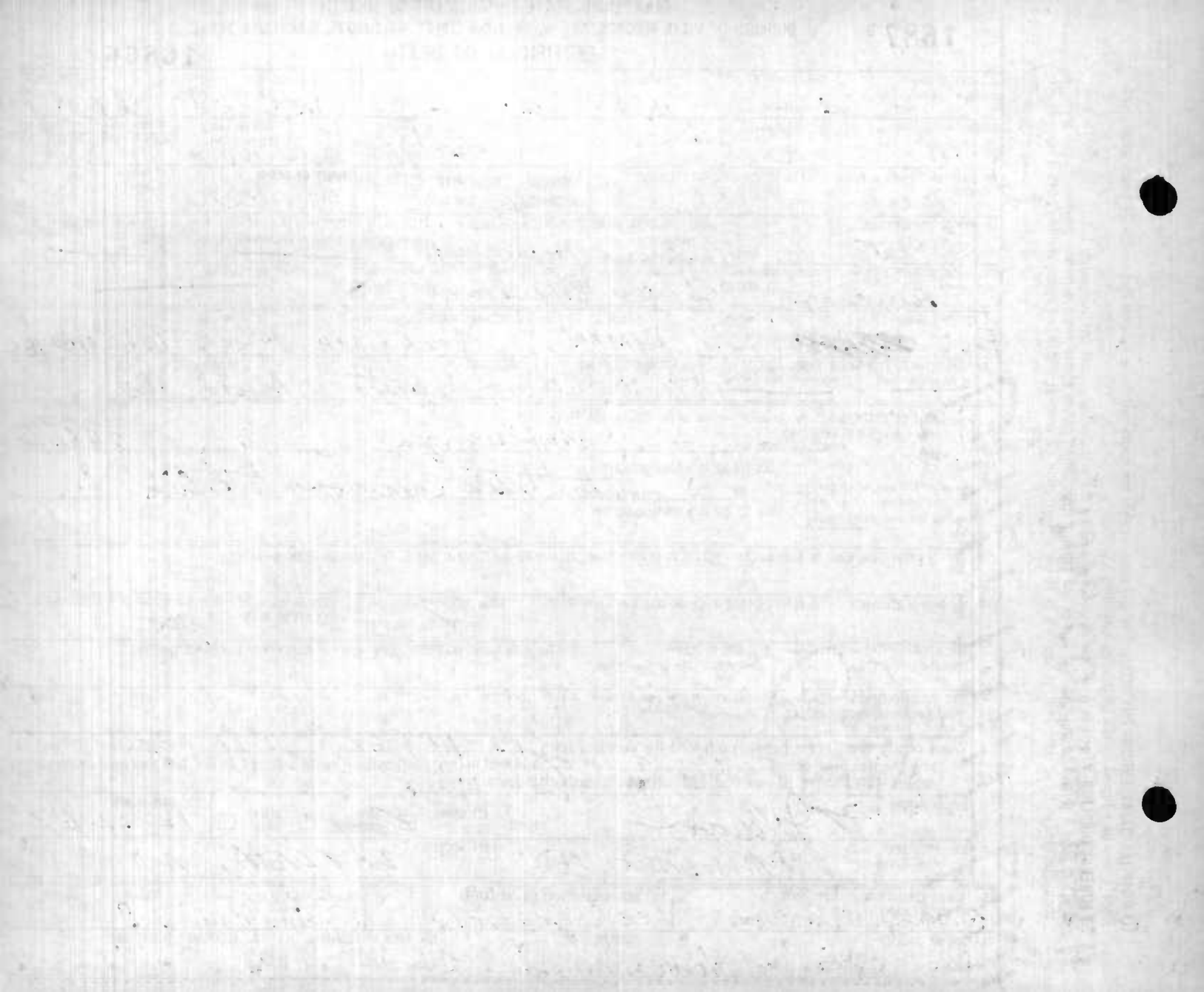
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
JOHN BERNARD DAY			(PRESUMPTIVE IDENTIFICATION)			Month Day Year			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	Negro	4/15/49	18 YRS.	MONTHS	DAYS	HOURS	MIN	Month Day Year			8 A M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH					
MARBURY		MARYLAND		WIDOWED		CHARLES		Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Indian Head											
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
INDIAN HEAD			CHARLES			MARYLAND			YES NO		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
John			Edward DAY			Lena MARY			Queen		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
NO						Mother			EAST HOPPER LANE INDIAN HEAD MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Extensive thermal burns											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES NO			
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
PRIMARY OR CONTRIBUTING CAUSE OF DEATH				4:17 P.M. 12-22 19 67				Found just outside door of burned house			
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
WHILE AT WORK NOT WHILE AT WORK				House				Displaced vacant house, Rte. 210 Indian Head CHARLES Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner											
ACTUAL SIGNATURE				Charles S. Springate, M.D.				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				Charles S. Springate, M.D.				March 8, 1968			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL				3-25-68		St. Joseph's		Pomonkey, Charles Md			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Mc Crimmon Funeral Home				Pomonkey, Md				MAR 22 1968			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
16873									
16866									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Sidney H. Diman						Dec 19 67			4:30 PM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
M		white		7/27/90			77 YRS.		HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Mass.		USA					Charles Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
La Plata			Physicians Memorial Hosp.						
13a. USUAL RESIDENCE (Where deceased lived, if instituting. Residence before admission)			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER
STATE Maryland			Charles			Cobb Island			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Fred Sidney L. Diman			Georgina Homer Del Cardayre						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT			
Yes, no, or unknown			579-26-3326A			Wm Barnett Arnold, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>influenza</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic Carcinoma to the liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>481 X</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>12-19, 1967</u> , to <u>12-19, 1967</u> , that (I) (we) last saw the deceased alive on <u>12-17, 1967</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
F.M. Johnson								12-21-67	
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
F.M. Johnson M.D.			LA PLATA, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Cremation			12-22-67		Lee Cemetery		Washington D.C.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Hardesty Funeral Home			Aunnipolis Rd			DATE JAN 2 1968		Charles Judge	





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1687

1687

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Charles</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>La Plata</b> c. LENGTH OF STAY in 1b  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Physicans Memorial Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Charles</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b> d. STREET ADDRESS <b>Oak Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>WILLIAM AUGUSTUS FOWKE Fowke</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>December 3, 1967</b>		<b>5. SEX</b> <b>Male</b>			
<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>June 4, 1892</b>			
<b>9. AGE</b> (In years last birthday) <b>75 yrs.</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Resident Engineer-Ret. State Roads</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>William A. Fowke</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Jane F. Stonestreet</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war/dates of service) <b>Yes 1916</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b>		<b>17. INFORMANT</b> Address <b>Agnes Fowke -Wife -La Plata, Md.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>Arterio Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Arterio Sclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mediastinal Tumor</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State) <b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>11-9-67</b> <b>to</b> <b>12-3-67</b> <b>that (I) (we) last saw the deceased alive on</b> <b>12-2-67</b> <b>and that death occurred at</b> <b>11-9-67</b> <b>M.</b> <b>from the causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <b>E.J. Edelen</b> <b>M.D.</b> <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22b. DATE SIGNED</b> <b>12/3/1967</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>E.J. Edelen, M.D.</b> <b>22d. ADDRESS</b> <b>La Plata, Md.</b>							
<b>23a. BURIAL, CREMATION, ETC.</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>12/5/1967</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Rest Cemetery</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Arehart Funeral Home, Inc.-La Plata, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DEC 7 1967</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>J. Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

RECEIVED  
JAN 10 1964  
U.S. AIR FORCE  
HEADQUARTERS  
WASHINGTON, D.C.

10. *Journal of the American Medical Association*, 277:1033-1034, 1997

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16875

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16868

1. PLACE OF DEATH o. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Chas</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maund</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
c. LENGTH OF STAY in 1b <u>1 yr</u>		d. STREET ADDRESS <u>08-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>THOMAS HILARY GRAY</u>		4. DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-4-09</u>
9. AGE (In years lost birthday) yrs. <u>58</u>		10. IF UNDER 1 YEAR Months <u>12</u> Days <u>24</u> Hours <u>19</u> Min. <u>67</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Handwritten Employer</u>		12. KIND OF BUSINESS OR INDUSTRY <u>U.S.A.</u>	
13. BIRTHPLACE (State, foreign country) <u>Md</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>John Gray</u>		16. MOTHER'S MARRIAGE NAME <u>Theresa Washington</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		18. SOCIAL SECURITY NO. <u>214-18-0009</u>	
19. INFORMANT <u>Charles J. Berry</u>		Address <u>Indian Head Charles Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Carotid Artery Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>12-24-67</u> (b) <u>12-24-67</u> (c) <u>12-24-67</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12-24-67</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21a. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	21b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	21c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	21d. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>F. J. Edler</u> M.D.		22. DATE SIGNED <u>12-24-67</u>	
EXAMINER'S NAME (Type) <u>F. J. EDLER</u>		Address (Street, city, town, or county) <u>Indian Head Charles Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>12-27-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	23d. LOCATION (City or Town) (County) (State) <u>Indian Head Charles Md</u>
24. FUNERAL DIRECTOR <u>Leroy E. Berry-Huntingtown Md</u>		25a. REC'D BY REGISTRAR <u>DEC 27 1967</u>	
ADDRESS <u>Leroy E. Berry-Huntingtown Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Berry</u>	

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FOR STATE  
HEALTH DEPT.

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VR A15ME (5)  
6M 1/67

16876

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16869

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>				c. LENGTH OF STAY IN 1b <b>White Plains</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physicians Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>James Edward Hamilton</b>				4. DATE OF DEATH Month Day Year <b>December 16, 1967</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cau.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 14, 1914</b>	
9. AGE (In years lost birthday) yrs. <b>53</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Roy Hamilton</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Pickeral</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-14-5036</b>		17. INFORMANT <b>Roy Hamilton, White Plains, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>12/16/67</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>E.J. Edelen M.D.</b>				22. DATE SIGNED <b>Dec. 16, 1967</b> <b>La Plata, Md.</b>			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-18-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Waldorf, Charles, Md.</b>	
24. FUNERAL DIRECTOR <b>Huntt Funeral Home, Waldorf, Md.</b>				25a. DECEASED BY REGISTRATION <b>DEC 21 1967</b> DATE			
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

1887

Charles

Marjand

Charles

in Paris

White Plains

Thelma Memorial Hospital

James

Edward Hamilton

December 10,

87

Gen.

Aug. 14, 1914

X

Carpet

Construction

Marjand

U.S.A.

Ray Hamilton

Armed Forces

No

11-14-1914

Ray Hamilton, White Plains, N.Y.

Dec. 10, 1907  
in Paris, N.Y.

E. J. Nelson N.Y.

Paris

11-14-1914

Edward Hamilton

Raymond, Chicago, Ill.

Raymond, Chicago, Ill.



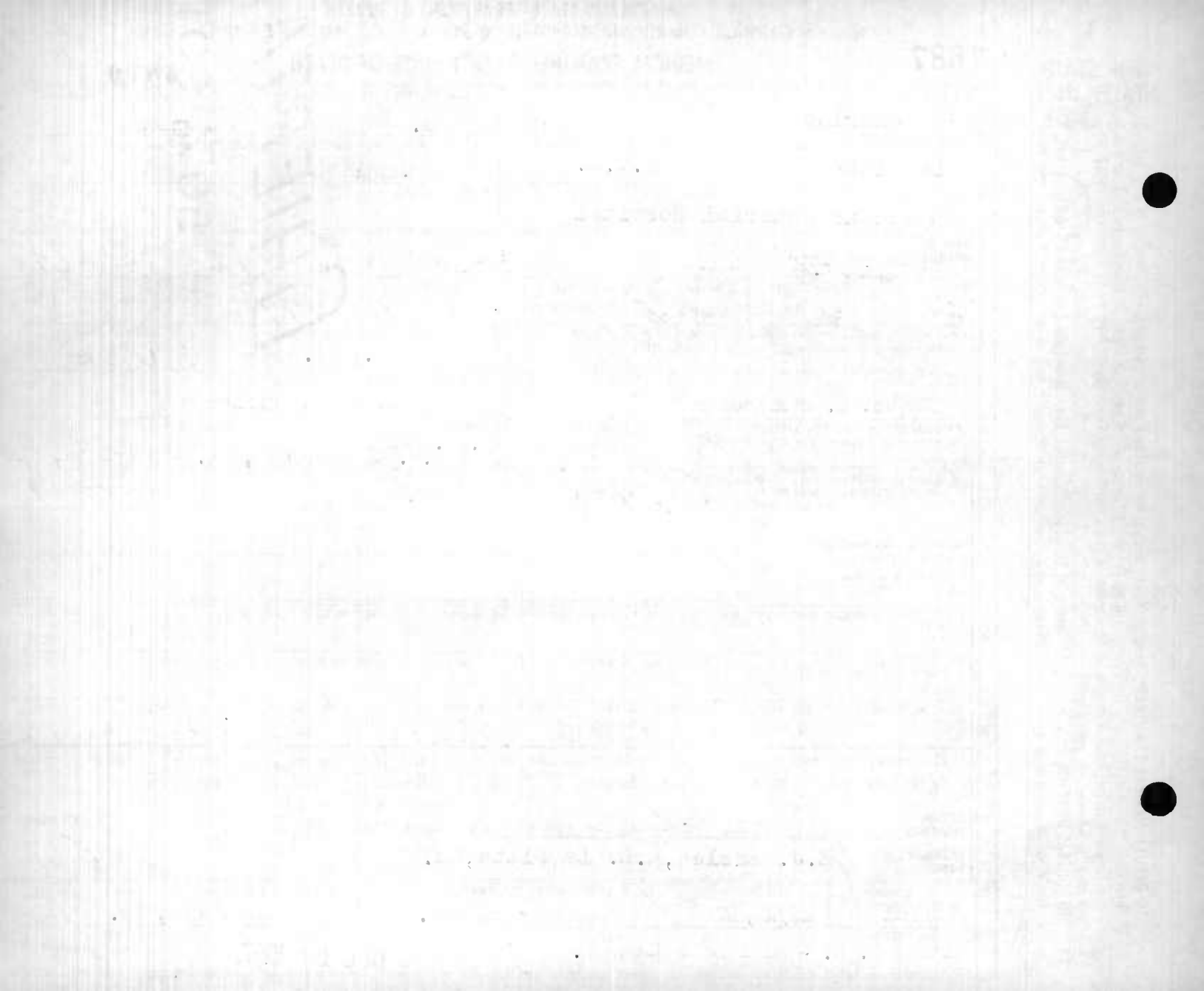
1  
2  
FOR STATE HEALTH DEPT.  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16877

16870

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physicans Memorial Hospital</b>		d. STREET ADDRESS <b>La Plata</b>	
3. NAME OF DECEASED (Type or print) <b>LYDIA</b> First Middle Last		4. DATE OF DEATH <b>HOLMES</b> Month <b>12</b> Day <b>15</b> Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-24-90</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <b>77</b>
11. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wm. S. Steinacker</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Heisler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Wm. G. Holmes</b>		Address <b>1209 N.W. 11th Terrace, Ft. Lauderdale, Fla</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>12-15-67</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>
20f. (City or town) <b>La Plata</b> (County) <b>Charles</b> (State) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>E.J. Edelen</b> M.D.		22. DATE SIGNED <b>12-15-67</b>	
EXAMINER'S NAME (Type) <b>E.J. Edelen, M.D. La Plata, Md.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/19/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Witzke F. D. - 4101 Edmondson Av.</b>		25a. REC'D BY REGISTRAR <b>DEC 19 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles J...</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

16878		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. LENGTH OF STAY IN 1b <u>Rock Point</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Physician's Memorial Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Charles Elizha Hudson Jr.</u>		4. DATE OF DEATH <u>12</u> Month <u>3</u> Day <u>67</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1931</u> Dec. <u>25</u> , <u>1931</u>
9. AGE (In years lost birthday) <u>35</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES Hudson</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Campbell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>263-40-1772</u>	
17. INFORMANT <u>Ida Mae Thomas, Rock Point, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple crushing</u> DUE TO (b) <u>injuries to chest</u> DUE TO (c) <u>fire &amp; gas explosion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12-3-67</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Head on auto accident (Driver)</u>	
20c. TIME OF INJURY Month, Day, Year <u>4:15 P.M. 12-3-67</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>Highway</u> (County) <u>Charles</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <u>12-3-67</u>	
ACTUAL SIGNATURE <u>E.J. Edelen</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E.J. Edelen, La Plata, Md.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 9, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Shiloh Methodist</u>		23d. LOCATION (City or Town) <u>Newburg, Charles, Md.</u> (County) (State)	
24. FUNERAL DIRECTOR <u>Berry Funeral Home, Pomonkey, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 7 1967</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1887

London  
New York

London, 1887

Dec. 1, 1887

1887

London

Dec. 1, 1887

Dec. 1, 1887

1887

Dec. 1, 1887

Dec. 1, 1887

Dec. 1, 1887

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16879

CERTIFICATE OF DEATH

16872

1. PLACE OF DEATH o. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>New Hampshire</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAPLATA</b>		c. LENGTH OF STAY IN lb <b>5 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ossipee</b>		1663	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PHYSICIANS MEMORIAL HOSPITAL</b>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>RUTH S. LIVINGSTON</b>		4. DATE OF DEATH Month <b>DEC</b> Day <b>14</b> Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-1-1890</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>New Hampshire</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Edwin Stevens</b>		14. MOTHER'S MAIDEN NAME <b>Lucy Smith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>Mrs. James McCallum</b>		Address <b>321 Avenue C., New York City</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Collapse</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Cerebral vascular accident</b> DUE TO (c) <b>Hypertensive Cardio vascular disease</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>4 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9 Dec 1967</b> , to <b>14 Dec 1967</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>14 Dec 1967</b> , and that death occurred at <b>12:15 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Arthur P. Wooddy MD</b>		22b. DATE SIGNED <b>14 Dec 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARTHUR P. WOODDY MD</b>		22d. ADDRESS <b>LAPLATA, MARYLAND 20646</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>Ded. 15, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lee Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR <b>Arehart Funeral Home Inc., La Plata, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE DEC 19 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>																																											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Charles</u> <span style="float: right;">MARYLAND</span>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Charles</u> <span style="float: right;">b. COUNTY <u>MARYLAND</u></span>																																					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Indian Head, Md</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>																																					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Physician Memorial Hospital</u>						d. STREET ADDRESS <u>Kaplan Ave</u>																																					
<b>3. NAME OF DECEASED</b> (Type or print) <u>MARY</u> <span style="float: right;">First</span> <u>Estella</u> <span style="float: right;">Middle</span> <u>Matthews</u> <span style="float: right;">Last</span>						<b>4. DATE OF DEATH</b> <u>12</u> - <u>11</u> - <u>1967</u>																																					
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>Negro</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>3/4/1904</u>		<b>9. AGE</b> (In years last birthday) <u>63</u> yrs. <table border="1" style="display: inline-table;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.																										
IF UNDER 1 YEAR		IF UNDER 24 HRS.																																									
Months	Days	Hours	Min.																																								
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>																																	
<b>13. FATHER'S NAME</b> <u>John Matthews</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Shelton</u>																																					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Agnes Smith</u> <span style="float: right;">Address <u>Risgah, Md</u></span>																																					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td colspan="10"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <u>C.U.A.</u> </td> <td colspan="2" rowspan="3"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>4 days</u> </td> </tr> <tr> <td colspan="10"> <b>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>  <b>(b)</b> <u>Hypertension</u> </td> </tr> <tr> <td colspan="10"> <b>(c)</b> <u>Sub. Arteriosclerosis</u> </td> </tr> </table>										<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>C.U.A.</u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>4 days</u>		<b>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <u>Hypertension</u>										<b>(c)</b> <u>Sub. Arteriosclerosis</u>										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>C.U.A.</u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>4 days</u>																																	
<b>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <u>Hypertension</u>																																											
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<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>																																											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)																																							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)																																			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>12/7</u> , 19 <u>67</u> , <b>to</b> <u>12/11</u> , 19 <u>67</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>12/11</u> , 19 <u>67</u> , <b>and that death occurred at</b> <u>11:30</u> M., <b>from the causes and on the date stated above.</b>																																											
<b>22a. SIGNATURE</b> <u>Arturo M. Monteiro</u>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>12/14/67</u>																																			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Arturo M. Monteiro</u>						<b>22d. ADDRESS</b> <u>La Plata, Md</u>																																					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)		<b>23b. DATE THEREOF</b> <u>12-15-67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Washington National</u>				<b>23d. LOCATION</b> (City, town or county) (State)																																			
<b>24. FUNERAL DIRECTOR</b> <u>Beane Funeral Home</u>						<b>ADDRESS</b> <u>Baltimore, Md</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DEC 20 1967</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>																																	

1944-1945

16881

## CERTIFICATE OF DEATH

16874

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. LENGTH OF STAY IN 1b <b>La Plata</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bryans Road</b>		d. STREET ADDRESS <b>Physicians Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>PAUL</b>		4. DATE OF DEATH <b>Dec 22 1967</b>		5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-11-1900</b>	
9. AGE (In years last birthday) yrs. <b>67</b>		10. IF UNDER 1 YEAR Months Days <b>67</b>		11. IF UNDER 24 HRS. Hours Min. <b>67</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AUTO PARTS</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AUTO</b>		11. BIRTHPLACE (County & State, or foreign country) <b>NEW YORK</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>LOUIS RIEDEL</b>		14. MOTHER'S MAIDEN NAME <b>UNK</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>233-03-4541</b>		17. INFORMANT <b>HATTIE RIEDEL, BRYANS RD., MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary artery disease</b> DUE TO <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INFLUENZA</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>18 Dec 1967</b> to <b>22 Dec 1967</b> that (I) (we) last saw the deceased alive on <b>22 Dec 1967</b> , and that death occurred at <b>8:50 M</b> , from causes and on the date stated above.		22a. SIGNATURE <b>Arthur O. Wooddy, MD</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARTHUR O. WOODDY, MD</b>		22d. ADDRESS <b>LAPLATA, MARYLAND - 20644</b>		22b. DATE SIGNED <b>23 Dec 67</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-27-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>TRINITY MEM. GARDENS</b>	
23d. LOCATION (City or Town) (County) (State) <b>WALDORF, CHARLES, MD.</b>		24. FUNERAL DIRECTOR <b>HUNT FUNERAL HOME, WALDORF, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		26. [Blank]		27. [Blank]	

1933

CONTINUED

11-11-1933  
NEW YORK

11-11-1933  
NEW YORK

11-11-1933  
NEW YORK

11-11-1933  
NEW YORK

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>NEW YORK</b> COUNTY <b>NEW YORK</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAPLATA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NEW YORK, N.Y.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PHY. MEM. HOSPITAL</b>		d. STREET ADDRESS <b>7 W. 81 ST.</b>	
3. NAME OF DECEASED (Type or print) <b>SAMUEL</b> First <b>RODMAN</b> Middle <b>LOD</b> Last		4. DATE OF DEATH Month <b>12</b> Day <b>10</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 15 1898</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SELF EMPLOYED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>REAL ESTATE</b>	11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>
13. FATHER'S NAME <b>BENJAMIN RODMAN</b>		14. MOTHER'S MAIDEN NAME <b>SARAH HERSHMAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MORRIS RODMAN</b>		Address <b>105-18 St., N.W. Washington DC</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>12-10-67</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>E. J. EDELEN</b> M.D.		22. DATE SIGNED <b>12-10-67</b>	
EXAMINER'S NAME (Type) <b>E. J. EDELEN, LAPLATA, MD</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>12-11-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lees Crematory</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington DC</b>
24. FUNERAL DIRECTOR <b>Crechut Funeral Home</b>		25. REC'D BY REGISTRAR <b>Charles Judge</b>	
ADDRESS <b>Laplata, Md</b>		DATE <b>DEC 15 1967</b>	

New York, N.Y.

April 15, 1941

Dear Sir:

Enclosed



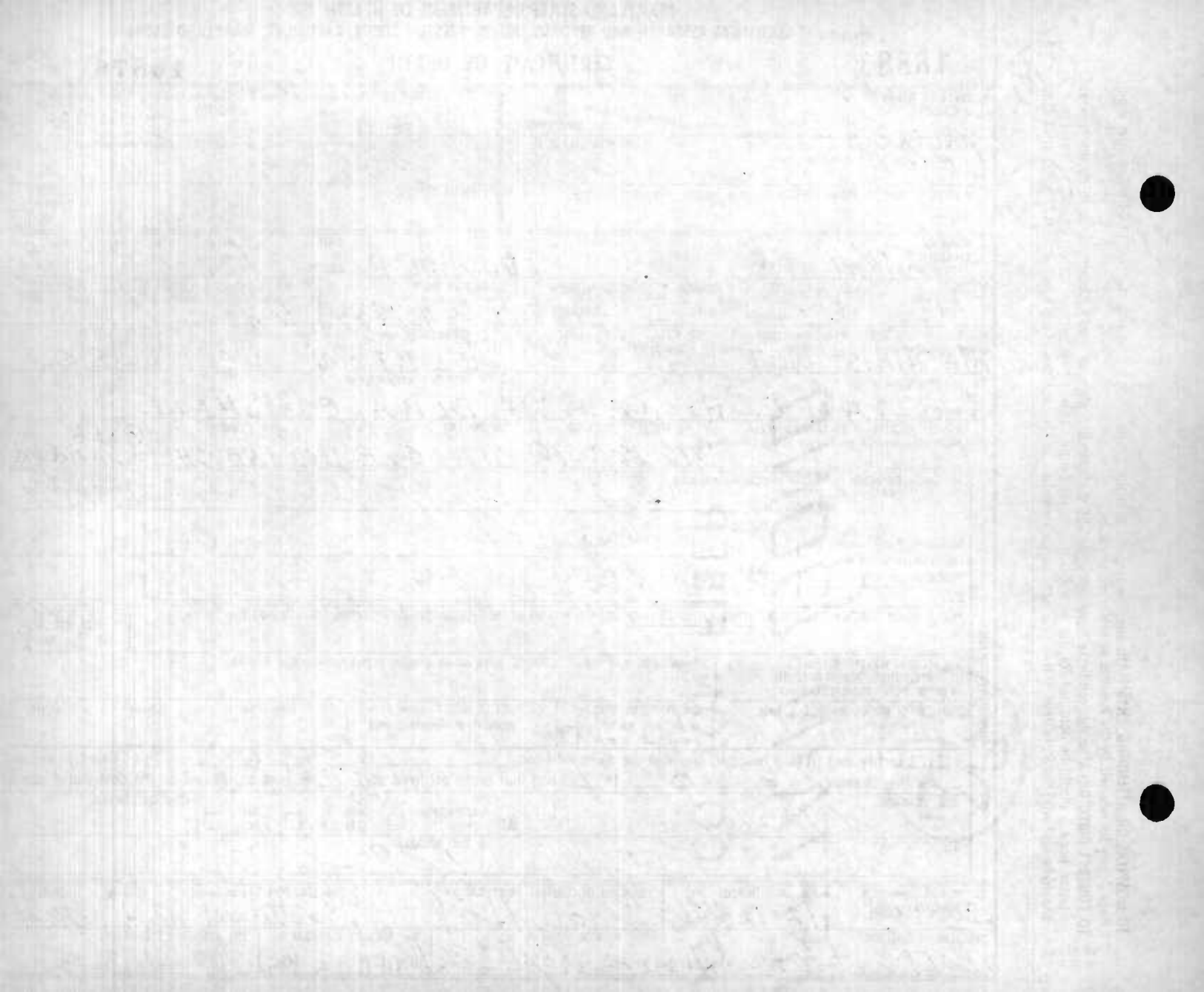
## CERTIFICATE OF DEATH

16876

1. PLACE OF DEATH o. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cocoa</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cocoa</u>	
c. LENGTH OF STAY IN 1b <u>4 yrs</u>		d. STREET ADDRESS <u>Med 08-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>IRWIN</u> First <u>E</u> Middle <u>RODABUSH</u> Last		4. DATE OF DEATH Month <u>12</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4 1899</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST RET</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>ELKTON VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM D. RODABUSH</u>		14. MOTHER'S MAIDEN NAME <u>DORA CUTSHALL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>818-155-031A</u>	
17. INFORMANT <u>MAGGIE RODABUSH</u> Address <u>0666 ISLAND MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension and</u> (c) <u>Gen-arc Acl</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>INTERVAL BETWEEN ONSET AND DEATH 12-8-67</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12-5</u> , 19 <u>67</u> , to <u>12-8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-8</u> , 19 <u>67</u> , and that death occurred at <u>2:15</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>E. J. EDELED</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>E. J. EDELED</u>		22d. ADDRESS <u>LA PLATA, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-12-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Swanton P.H. Md</u>	
24. FUNERAL DIRECTOR <u>Brabant Funeral Home and Chapel</u> ADDRESS		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>DEC 15 1967</u>	
25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

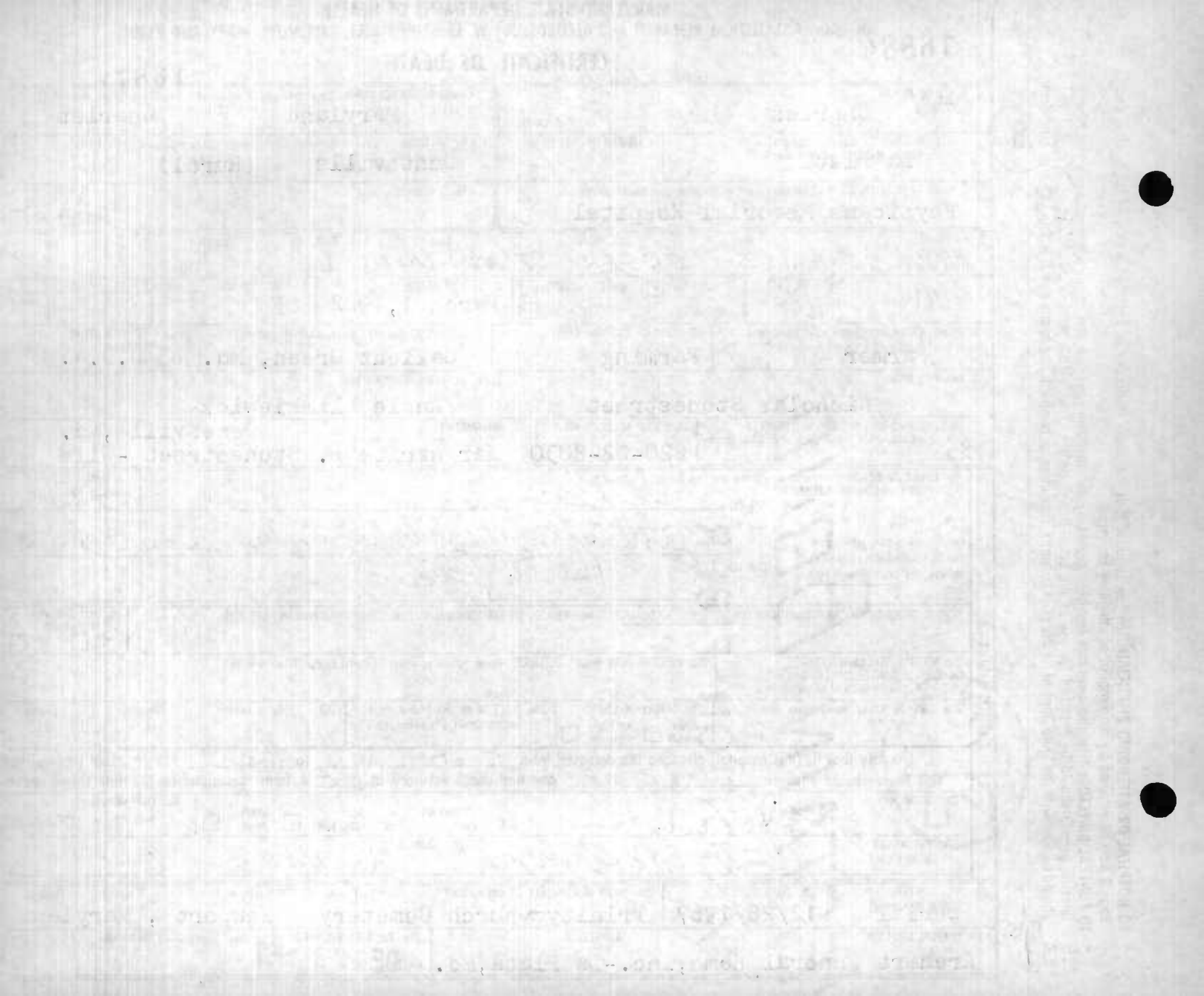


## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. LENGTH OF STAY IN lb <b>Dentsville (Rural)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physicans Memorial Hospital</b>		d. STREET ADDRESS <b>08-1</b>	
3. NAME OF DECEASED (Type or print) <b>JAMES EDGAR STONE STREET</b>		4. DATE OF DEATH Month <b>12</b> Day <b>25</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1, 1902</b>
9. AGE (In years last birthday) yrs. <b>65</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Gallent Green, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nicholas Stonestreet</b>		14. MOTHER'S MAIDEN NAME <b>Annie Klimkiewicz</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-22-8030</b>	
17. INFORMANT <b>Dentsville, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Influenza</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular disease</b> DUE TO (c) <b>(with failure)</b>	
19. INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct</b> , 19 <b>67</b> to <b>Dec</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12-25-1967</b> , and that death occurred at <b>11 A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>F.M. Johnson</b>		22b. DATE SIGNED <b>12-25-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>F.M. JOHNSON</b>		22d. ADDRESS <b>La Plata Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/28/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Church Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Newport, Maryland</b>	
24. FUNERAL DIRECTOR <b>Arehart Funeral Home, Inc.-La Plata, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 28 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>James Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

16885

16878

1. PLACE OF DEATH o. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. LENGTH OF STAY IN lb <b>La Plata</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physicans Memorial Hospital</b>		d. STREET ADDRESS <b>08-1</b>	
3. NAME OF DECEASED (Type or print) <b>VIOLA May SWANN</b>		4. DATE OF DEATH Month <b>12</b> Day <b>21</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>June 24, 1911</b>
9. AGE (In years lost birthday) yrs. <b>56</b>		10. IF UNDER 1 YEAR Months <b>21</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>File Searcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Charles County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>E. Leigh Edelen</b>		14. MOTHER'S MAIDEN NAME <b>Marguerite Willett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-22-0182</b>	
17. INFORMANT <b>Mrs. Betty Johnson-Daughter</b>		Address <b>La Plata, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>5810 IMMEDIATE CAUSE (a) CIRRHOSIS OF THE LIVER</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>OCT 12, 1967</b> , to <b>DEC 21, 1967</b> , that (I) (we) last saw the deceased alive on <b>12-21-1967</b> , and that death occurred at <b>6:30 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>12-22-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>F.M. JOHNSON MD</b>		22d. ADDRESS <b>LA PLATA, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/23/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Pomfret, Maryland</b>
24. FUNERAL DIRECTOR <b>Arehart Funeral Home, Inc.-La Plata, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 27 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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UNITED STATES

AMERICA

INDEPENDENCE

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

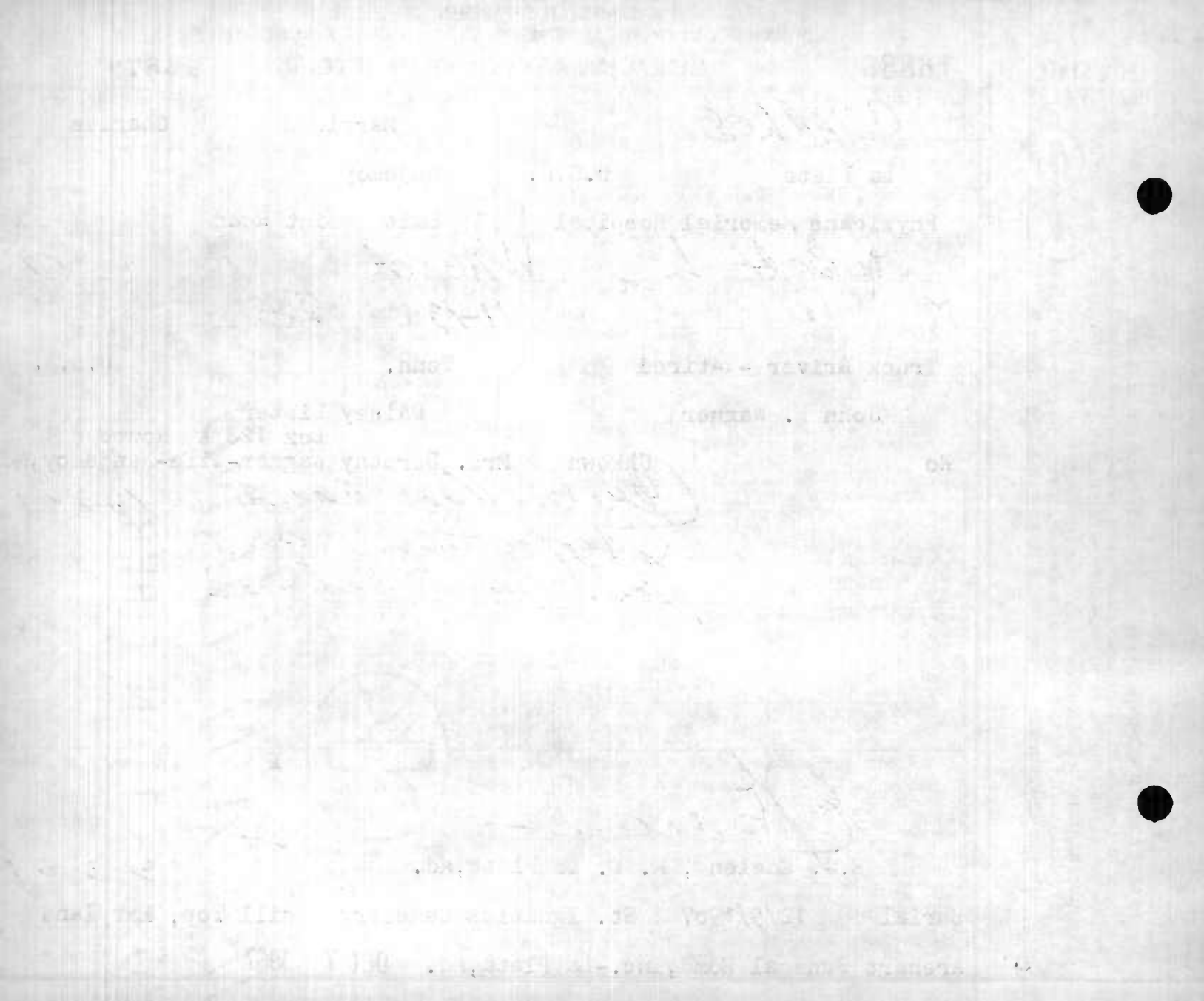
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16886

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16879

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physicians Memorial Hospital</b>		d. STREET ADDRESS <b>Smith Point Road</b>	
3. NAME OF DECEASED (Type or print) <b>ROBERT L. WAGNER</b>		4. DATE OF DEATH Month <b>12</b> Day <b>2</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-13-09</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver - Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Tenn.</b>	
13. FATHER'S NAME <b>John H. Wagner</b>		14. MOTHER'S MAIDEN NAME <b>Daisey Lister</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unkown</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chloroform accident</b> DUE TO (b) <b>Asphyxiation and</b> stating the underlying cause (c) <b>Heart and blood vessels</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>E. J. Edelen</b> M.D.		22. DATE SIGNED <b>12-2-67</b>	
EXAMINER'S NAME (Type) <b>E. J. Edelen, M. D. La Plata, Md.</b>		22. DATE SIGNED <b>12-2-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/5/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Ignatius Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hill Top, Maryland</b>	
24. FUNERAL DIRECTOR <b>Arehart Funeral Home, Inc. - La Plata, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 7 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Item 20 Film 396 12-18-67 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LaPlata</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hill Crest Hights</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>LaPlata Memo. Hospital</b>		d. STREET ADDRESS <b>2418 Iverson St.</b>	
3. NAME OF DECEASED (Type of print) <b>Lillian</b> First <b>William</b> Last <b>Williams</b>		4. DATE OF DEATH <b>12-2-67</b> Month <b>12</b> Day <b>2</b> Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-6-1910</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George Knott</b>		14. MOTHER'S MAIDEN NAME <b>Ida R. Barber</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>John Simms</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>816.4</b> IMMEDIATE CAUSE (a) <b>Acc Neurosurgery</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Aneurysm</b> (c) <b>Chronic</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12-2-67</b> <b>12-3-67</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in car head on rear collision</b>	
20c. TIME OF INJURY Hour <b>4:30</b> Minute <b>30</b> Month <b>12</b> Day <b>3</b> Year <b>1967</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Wayside Charles Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>[Signature]</b>		22. DATE SIGNED <b>12/3/67</b>	
EXAMINER'S NAME (Type) <b>[Signature]</b>		M.D. <b>[Signature]</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-7-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR <b>Lee Funeral Home</b>		ADDRESS <b>Washington, D.C.</b>	
25a. REC'D BY REGISTRAR <b>DEC 8 1967</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

Two for 1 certificate Film #G397 1/25/68 ph

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

16888

16881

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pomfret</u>		c. LENGTH OF STAY IN lb <u>LIFE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>Hoffman</u> Middle <u>Winkler</u> Last		4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 19, 1898</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>08</u> Days <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pomfret, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anthony Winkler</u>		14. MOTHER'S MAIDEN NAME <u>Emily Adams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-38-7711</u>	
17. INFORMANT <u>Helen G. Winkler, Pomfret (Md.)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Stroke</u> (c) <u>See above</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-24-67</u> to <u>12-25-67</u> , that (I) (we) last saw the deceased alive on <u>12-24-67</u> , and that death occurred at <u>12-25-67</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>Edward J. Edelen</u>		22b. DATE SIGNED <u>12-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward J. Edelen MD</u>		22d. ADDRESS <u>La Plata, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-28-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland Chas. Md.</u>
24. FUNERAL DIRECTOR <u>The Hunt Funeral Home, Waldorf, Md</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 29 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Richard J. Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF TEXAS

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STATE OF TEXAS  
COUNTY OF DALLAS  
I, the undersigned, Clerk of the County of Dallas, Texas, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the County of Dallas, Texas.